HIPAA Release Form

SOUTH MILWAUKEE FAMILY DENTAL
MICHAEL K SHINNERS, DDS,SC

Patient Name: _____ Date: _____

Privacy regulations require us to have a release signed by our patients, so we may speak with family members, friends and other relations regarding your Protected Health Information.

Description of Protected Health Information

I understand that my Health Information includes individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data. Authorizing an individual of my choosing will grant them access to medical records, providers, appointments, and any health information.

Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other). Please print name, relationship, and telephone number for each person to whom you are authorizing release of your protected health information (PHI) and account balances.

Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #
Name	Relation	Phone #

I understand that I may revoke this Consent at any time in writing. If I choose to revoke my Consent at any time, it will not affect any use or disclosures permitted by my authorization while it was in effect. This authorization, unless I revoke it earlier, shall remain in effect for as long as I am an active patient at Michael K. Shinners DDS.

Patient Signature _____ Date _____